Request for Release of Medical Records

From: Date:

To:

Subject: Request for release of medical records related to refractive surgery procedure

1. I am considering participation in a research study of refractive surgery in Army aviator training students. I request a copy of records pertaining to my refractive surgery be provided to:

PRK/LASIK PI
US Army Aeromedical Research Laboratory (Visual Science Branch)
Bldg 6901, PO Box 620577
Ft. Rucker, AL 36362
Voice: (334)255-6876
Fax: (334)255-6993

2. The following information is needed:

Date of procedure

Type of procedure (PRK or LASIK)

Type of laser (brand name)

Ablation parameters

Amount of correction (sphere, cylinder and axis)

Pre-operative refraction and date (specify manifest or cycloplegic)

Follow-up refractions and dates (most current refraction and as many postoperative refractions as possible)

Subjective assessment of corneal clarity (haze)

Post-operative corneal topography (instantaneous or tangential corneal maps, in color)

Contrast Sensitivity (or low contrast acuity)

Visual Acuity

3. Please complete the attached eye care provider checklist.

4. Please contact the PRK/LASIK PI if you have any questions.

_____ _____

Printed name of the study applicant Signed name of the study applicant

Checklist for Eye Care Provider

Study Applicant

Last Name:_____ First Name:_____ Middle Initial: _____

Date of Birth:_____ Contact Tel.#: _____

Eye Care Provider

Name:_____ Date of Report:_____

Clinic Address & Telephone: _____

_____

Specific Procedure Details

Date of Procedure:_____ Type (***circle one***) **PRK or LASIK**

Laser Used: (Manufacturer)_____ Model #_____

Ablation parameters (Complete below, or if available, attach copies of laser records)

OD: Size of ablation:_____*mm* Tissue Removed:_____microns # of Pulses:_____

OS: Size of ablation:_____*mm* Tissue Removed:_____microns # of Pulses:_____

Amount of correction programmed into laser

OD:_____ OS:_____

Preoperative refraction

OD:_____ OS:_____

Did the applicant require any enhancement procedures? Yes_____ No_____

(If yes, please provide details, as above)

Follow-up examinations (include most recent and 2 prior examinations

Date	**Refraction**	**Visual acuity**	**Corneal haze* (circle one)**
	OD_____	OD_____	OD 0 1 2 3 4
_____	OS_____	OS_____	OS 0 1 2 3 4
	OD_____	OD_____	OD 0 1 2 3 4
_____	OS_____	OS_____	OS 0 1 2 3 4
	OD_____	OD_____	OD 0 1 2 3 4
_____	OS_____	OS_____	OS 0 1 2 3 4

Haze 0-4 scale. 0=no haze, 1=trace, 2=minimal, 3=moderate, 4=iris details obscured.

Checklist for Eye Care Provider

Corneal topography (include copy of most recent corneal topography using the TANGENTIAL or INSTANTANEOUS map display option)

Topographer used:

_____

Manufacturer:

_____

Model:

_____

Date of topographies:

_____

Contrast sensitivity (Attach copy of results, if available)

Test Used:

Manufacturer:

_____

Model:

_____

Date of contrast test:

_____

Test Conditions:

Room Lights ON (circle one) Yes No

Backlit Chart (circle one) Yes No

Distance to test _____m

% Contrast (if letters) _____%

Results:

OD_____

OS_____

Thank you for completing the information. Please return this form and supporting records to:

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